Group Practice Management Newsletter

May 2003

GPM Day at the AFMS Resources Conference in San Antonio, 14 May 03

We will hold our first annual GPM Day as a part of the AFMS Resources Conference at the Hyatt Regency on the Riverwalk in San Antonio, 14 May 03. All GPMs are invited to attend... no registration is necessary for GPM Day activities, but registration is required to attend other Resources Conference functions. This is a unit funded TDY for most GPMs...The Resources Conference registration/ information web site is: https:// / www.afms.mil/ webregister_homepages/ mrc/ 2003/ . Complete agenda for all scheduled GPM Day presentations is provided below. All of our GPM presentations will be made available for download on the GPM web page (see page 7 for URL) immediately following the event. Please direct any question you may have regarding GPM Day to Maj Hyzy at DSN 736-1197, (jerome.hyzy@sheppard.af.mil).

GPM Day at the AFMS Resources Conference
Wed, 14 May 2003

TIME	Attendees	DESCRIPTION	ROOM	SPEAKER(S)
0730-0800	GPMs	Overview/Opening Remarks	TBA	Col Taylor
0800-0830	GPMs	Past, Present, Future of Practice Management in AFMS	TBA	Maj Hyzy
0830-0900	GPMs	Specialty Care Optimization	TBA	Maj Sales
0900-0930	GPMs	GPM Role in Preparing for, Surviving, and Exceeding Standards for HSI/JCAHO	TBA	Maj Lefebvre
0930-1100	GPMs	Access to Care: Mastering CHCS to Book Appnts	TBA	Mr Dave Corey
1100-1130	GPMs	P2R2 Access Metric Review	TBA	Mr Dave Corey
1130-1300	GPMs	LUNCH		*On Your Own*
1300-1330	GPMs	Eielson AFB Appointment Supply/Demand Tool	TBA	Maj Wood
1330-1430	GPMs	Service Management Tools: Creating Access and Satisfaction in the Value Chain (Part 1)	TBA	Mr Flowers/Ms Obrien
1430-1530	GPMs	Service Management Tools: Creating Access and Satisfaction in the Value Chain (Part 2)	TBA	Mr Flowers/Ms Obrien
1530-1600	GPMs	Luke AFB "Red Dragon" Appointing	TBA	Capt Pietrykowski
1600-1630	GPMs	GPM Portal Preview	TBA	Capt Goodwin
1630-1700	GPMs	In-House Patient Satisfaction Data Collection System	TBA	Capt Kimler

Red Dragon Open Access Works at the 56th MDG, Capt Pietrykowski,

Imagine an open access model that does "today's business today," but also provides immense flexibility in response to our increased readiness posture. On 3 March 03, the 56th Medical Group at Luke AFB unleashed Red Dragon Open Access, and patients and staff can't stop smiling! The Red Dragon concept was originated by our Air Force Surgeon General in response to the evolving role of the family practitioner in deployment, and how the in-place MTF must flex to meet the demand left behind. The key is unempanelling a provider on each team, whose template is full of OPAC appointments. Empanelled providers on the team must increase their capacity beyond 1500 in order to make this a reality, but with full knowledge that the unempanelled provider is their healthcare delivery partner on the team.

Early results have been terrific. Patients are seeing their own Primary Care Manager (PCM) or the unempanelled PA on their team over 95% of the time…cross-booking has virtually been eliminated. While PCM continuity, patient access and the no-show rate have improved dramatically under Red Dragon, the real beauty of the model lies in the flexibility offered by the unempanelled provider. "When a PCM is deployed, the other providers no longer have to scramble to fit in the patients left behind along with their own patients. They simply roll over to the unempanelled provider," says Col Don Taylor, 56 MDG/ CC. "It's what peacetime healthcare brings to the fight." The same concept holds true when a PCM is TDY or on leave.

Red Dragon Open Access Works at the 56th MDG
Capt Susan Pietrykowski, Senior Group Practice Manager (continued)

Based on the model's success, Luke will "unleash the Dragon" on all of its family practice teams on 5 May. Please see the attached briefing for more information on Luke's implementation of the Red Dragon.


"Red Dragon.ppt"

GPM Course/ Training News: Maj John Hyzy, GPM Course Director/ Instructor

In-Residence Course: Our projected remaining FY03 in-house courses are scheduled for: 16-20 Jun, 4-8 Aug, 22-26 Sep. During FY04, we will hold a resident GPM Course every month in the schoolhouse with 10 centrally funded seats per class. Each MAJCOM is allocated centrally funded slots to the GPM course every year. To attend the in-residence course, notify your MAJCOM through your Unit Training Manager and seek one of the centrally funded slots. If your MAJCOM runs out of slots and your unit is willing to fund you locally (travel and per diem), contact Maj Hyzy (jerome.hyzy@sheppard.af.mil) to discuss the possibility of attending an upcoming class as an "overage".

New GPM Mobile Course Now Available: We recently developed and are now offering a mobile version of the GPM course. To date, we have taken the GPM course on the road to Wilford Hall, TRICARE Region 3 (Augusta, GA), Luke AFB, Travis AFB, and Andrews AFB. Future mobile events are under consideration for Hickam, Lemor Naval Hospital (CA), and Davis-Monthan later this summer. If you wish to attend one of these events, contact a GPM at one of the hosting MTFs. To request a mobile event at your MTF, contact Maj Hyzy for more information.

GPM Field Consultants

We designed the GPM Field Consultant program to recognize the achievements of our experienced GPMs in the field, enhance the sharing of knowledge and successful techniques, and provide a forum for our experienced GPMs to help mentor/ grow younger/ newer GPMs. Listed below (by critical GPM skill area) are our GPM Field Consultants for FY03:

CHCS Scheduling and Templating: Maj Susan Baker (Lakenheath DSN: 226-8466), Capt Meredith Shephard (Hanscom DSN: 478-5030), Capt Sharon Goodwin (Wright-Patt DSN: 787-9240), 1Lt Mollie Yazzie (Luke DSN: 896-9375),

CHCS Reporting: Maj Rachel Lefebvre (Travis DSN 799-5279), Capt Meredith Shephard (Hanscom DSN 478-5030)

Coding Support: Maj Steve Sales (Academy DSN 333-5509), Maj Susan Baker (Lakenheath DSN 226-8466), Capt Susan Pietrykowski (Luke DSN 896-8992), Capt Jacqueline Bowers (certified coder) (Minot DSN 453-5473), Capt John McKenna (Tinker DSN 884-2896), Lt Michelle Stoffa (Bolling DSN: 754-6154)

Customer Satisfaction: 1Lt Dianna Kimler (Robins DSN 497-7986), Capt John McKenna (Tinker DSN 884-2896)

Demand Analysis: Maj Bill Wood (Eielson DSN: 317-377-6646), Maj Steve Sales (Academy DSN: 333-5509), Capt John McKenna (Tinker DSN 884-2896), Capt John Ginnity (Ramstein DSN 479-2504), Capt Sharon Goodwin (Wright-Patt DSN: 787-9240, 1Lt Mollie Yazzie (Luke DSN: 896-9375)

Marketing: Mrs. Lisa Carducci (dedicated PCO marketing specialist) (Scott DSN 576-7704)

Management of PCO Team Medical Records: Maj Dawn Rowe (HQ AFMC DSN 787-6633)

Measurement of Access to Care: Mr Dave Corey (SGMA DSN 761-4445 ext 3050, Maj Marissa Koch (SGMA DSN 761-4445 ext 3048, Maj Rachel Lefebrve (Travis DSN 799-5279), Maj Melinda Weiss (Scott DSN 576-7311 ext 4413), Capt John McKenna (Tinker DSN 884-2896), Capt Meredith Shephard (Hanscom DSN: 478-5030), Capt Sharon Goodwin (Wright-Patt DSN: 787-9240), 1Lt Mollie Yazzie (Luke DSN: 896-9375)

PCO Referral Tracking/ Management: Maj Mike Petronis (LAR3 DSN 773-2717), Capt John Ginnity (Ramstein DSN 479-2504), Capt John McKenna (Tinker DSN 884-2896)

Private Sector Care Recapture: Maj Mike Petronis and Ms Gerrie Pinckney (LAR3 DSN 773-2717), Maj Steve Sales (Academy DSN 333-5509)

Feel free to contact these GPMs/ field experts for thoughts/ ideas/ advise on projects you are working that relate to their listed specialty... Additionally, if you would like to be listed as a future GPM Field Consultant, contact Maj Hyzy and briefly describe your area of interest and the experience you think you can offer our GPMs. We will update this roster with each publishing of the GPM Newsletter. Many thanks to all the above-listed GPMs who graciously volunteered their demonstrated talents!

Leveraging the Power or Your Appointment Telephone System: Capt Berthe, Sheppard GPM

In this era of computers and the internet, it can be easy to focus on new technologies and forget about some of the old ones. One such oldie we sometimes fail to leverage is the telephone. Telephones are like dumb terminals connected to a mainframe computer, the phone switch. That phone switch is typically a multi-million dollar mainframe computer. As such, it has tremendous capabilities; however, you have to know what you want it to do. And here is where many of us fall short; it's just not something we've dealt with before.

While there are many ways we can leverage phones in healthcare, a few of the basics are call coverage, pickup groups, voice mail, and phone menuing systems. Call coverage means what happens to incoming phone calls if you don't answer – does the call automatically forward to another phone? Pickup groups, not referring to a gaggle of young adults outside a nightclub, is a feature that enables you to answer another ringing phone in your area. If you hear a phone ringing; regardless of which number or where that phone is, you can pick up your receiver, dial a code, and answer that call. Voice Mail. We all know what it is, the question is do we have access and do we know its advantages over an answering machine. Two advantages of voicemail are that patients/ customers can leave a message even if you're on the phone or someone else is leaving you a message. Another advantage is you can forward a message to a coworker's voicemail. So, if you, the GPM, receive a message that is really more appropriate for a team nurse, you can forward the message to him/ her. Other advantages may include the ability to speed up/ slow down messages as well as to skip ahead/ scan messages.

Lastly, phone menuing or automated call distribution (ACD) systems. There are many different things that can be done with an ACD system. They can route calls, i.e. "Press 1 for PCO Team 1…" They can deliver messages/ education, i.e. "All of our appointment clerks are currently busy, please…" or "Did you know that June is skin cancer awareness month…" They can queue calls to wait for the next available person and can even relay the expected wait time. An ACD system is essentially a small computer program. As such, you can change the call routing or messages delivered based on a conditional IF…THEN statement. The condition can be # of callers in queue, expected wait time, time of day, day of week, etc… From a management perspective, you can track how many callers chose a certain menu option, average hold times, # of patients who disconnected and how long they waited before doing so, # of calls answered by each appointment clerk, average time to handle each customer, and a host of other metrics.

At Sheppard, we recently leveraged this technology to improve patient satisfaction. We had a problem with patients waiting a long time on hold waiting to speak with central appointments. We placed a couple of new phones in Family Practice and Pediatrics so that from 0730 – 0830 (our busiest phone times) someone from the clinics can man each of those phones and augment our central appointments desk. The new process is invisible to our patients, but by reducing long on-hold times it removed a HUGE irritant. TRICARE On-Line should alleviate some of these issues; however, since you're still going to have patients calling you, give some thought to how you can simplify phone calls for them. Some of these technologies might help

Improve Access by Decreasing Incorrectly Booked Appointments: Maj Shephard, Hanscom GPM

Here at Hanscom we have historically been at between 84% and 87% in ROUT access. Our ACUT access has always been great (at or above 96%) and WELL has been 90%+. We felt we were doing better than what the P2R2 metric reflected, both in ROUT and WELL access. I have an ad hoc in CHCS to identify (by day, week, month, etc) all appointments booked by SHMS (our contractor) and by our MTF. Thanks to Capt Bobby Christopher for the ad hoc! This has proved to be an invaluable tool. I discovered in the first few months that 38% of all appointments booked were booked incorrectly. This impacted us in several ways:

- If a true follow-up (EST) was booked as a routine (ROUT) appt, it took a precious ROUT appt away from someone who really needed it, as ESTs can be booked far out, and we are restricted to a 7-day window for routines. This was determined by matching the appt type with the appt comment.

- The use of Future ATC search impacts access. The % Future searched use should roughly match the % of EST and GROUP in your templates. Similarly, if all appointments are not matched (appt type and ATC search type), metrics are negatively affected. 100% of appts booked should match the ATC search used.

- I also looked at ROUT appointments booked out more than 7-days. I discovered the CHCS Patient Refusal screen was not being adequately utilized, and we were busting standards even in cases where the patient had declined an appointment within standards.

I held remedial appointment booking training for all 4Ns, 4As, and nurses. We covered the basics of booking, access standards, matching appts with ATC booking procedures, and CHCS Patient Refusal Screens. I had them sign off that they received training and understood the booking process.

Improve Access by Decreasing Incorrectly Booked Appointments: Maj Shephard, Hanscom GPM (continued)

I run the ad hocs daily (Ad Hoc attached below) and counsel any 'offenders' in house. I also fax the reports to our contractor and work very closely with the appointment clerk supervisor to ensure they are receiving proper training and counseling. As of today, 16 April 2003, we are down to 15% mis-booked (still early in the improvement process), and 20 ROUTs booked outside of access standards. This is a very high interest item for our group commander (and MAJCOM), and I personally brief him each week on our progress. I appreciate his willingness to let me find ways to improve the problem. It's a very labor-intensive process, but has proved to be worth the extra effort. We are looking forward to staying in the yellow and soon venturing into the green in P2R2!


AdHoc.doc

ATC Measurement Training Update: Maj Koch and Mr Dave Corey (SGMA Access OPR/ Consultant)

The Air Staff folks at SGMA have put together a superb training presentation on the proper use of CHCS to search for and book appointments. This presentation can be tremendously helpful as a resource to assist you in getting a grip on the front-end for your practice and improving service/ access to appointments for our customers. This information will also help you better understand how CHCS and P2R2 measure access to care.

Also attached here are the three most recent Access to Care Bulletins published by SGMA...great, timely, and detailed information for all the GPMs/ Access Managers out there to stay on top of technical issues in CHCS.


"ATC Improvement Bulletin No. 1.doc"


"ATC Improvement Bulletin No. 2.doc"


"ATC Improvement Bulletin No. 3.doc"


"Acc Mgmt Trng.ppt"

Specialty Care Optimization at the Air Force Academy: Maj Sales, Senior USAFA GPM

The 10th Medical Group has been the Air Force pilot for four of five specialty care optimization (SCO) product lines. Analyzed product lines at USAFA include Orthopedics, General Surgery, ENT, and Ophthalmology. The purpose of the pilot was to test the staffing models developed by Air Staff and attempt to recapture surgical workload from the network. Consistent with the AF/ SG paradigm of ECA/ CCA/ BCA, the primary focus was to increase workload in the direct care system, increase case mix index for assigned surgeons, and to reduce Private Sector Care costs.

The first step in optimizing the analyzed product lines was to determine the correct number of surgeons required in each specialty based on population served; much like the PCO concept of 1500 enrolled beneficiaries per PCM. Each surgeon then drives a requirement for a certain number of nurses, PAs, medical technicians, and administrative technicians. Many of you will be familiar with these new models as they are included in your facility's staffing model for FY 2004. As GPMs you may be asked to bring expertise gained in PCO into the SCO clinics to improve operations. You may analyze templates, schedules, appointment booking, records management, etc. to help improve efficiency and productivity. Surgical specialties however, have more variables in the productivity equation than do primary care clinics. Clinic productivity does not equate to throughput. Throughput is determined by surgical cases performed.

The first order of business is to analyze your current workload, examine each piece of the process to determine capacity, then determine which piece is the bottleneck. Our role as GPMs is to analyze the system and recommend ways to improve productivity and efficiency. Examine your process in reverse. Surgical patients end up in beds (bed days). They get there via the OR. They arrive in the OR via the clinic (SCO). They get to the clinic via referrals from primary care (PCO). They access primary care by being enrolled in Prime (enrollment/ access). All the pieces must fit together into an optimized healthcare system (HCO).

Enrollment → PCO → Referrals → ECA/ CCA/ BCA → SCO → Surgeries → Bed Days → Reduced PSC Bills → RSVP → Staff Sat. = **HCO**

SCO will require you to get smart on your inpatient business as well. How many ambulatory surgery (ASU) beds do you have? How many same-day surgery cases per day do you anticipate doing with the added capacity? If caseload increases how many ASU beds will your facility require to satisfy demand? How many multi-service unit (MSU) beds does your facility have? What's your ADPL? How many admissions are surgical vs. medical patients? How many beds are occupied with observation (non admit) patients each day? How many beds are filled each day? What is you facility's average length of stay (ALOS)? Do you expect surgical admissions to increase? If so, how many additional beds and staff do you need?

At USAFA, our system looks like an hourglass with the OR being the bottleneck. Our facility has more surgeons than the infrastructure can adequately support. OR time is a finite capacity and as such, determines the throughput of the USAFA healthcare system. The tough part comes in determining how to allocate the scarce resource.

Specialty Care Optimization at the Air Force Academy: Maj Sales, Senior USAFA GPM (continued)

ECA/ CCA/ BCA becomes very important when you analyze referrals to determine which cases stay in direct care and which go to the network. You may be called upon to recommend entire services to be outsourced to the network. Here perhaps more than anywhere else is the value of the GPM skill set realized.

In the final analysis, USAFA spent $2.9M, hired 45 additional contract staff members (many through resource sharing), opened a fourth operating room, changed some business processes, and purchased some new equipment and supplies. We assigned a GPM and HCI to SCO, hired a tremendous data analyst and an experienced coder to implement superbills in the specialty clinics and train surgeons on proper coding. So what were the results? OR cases per day increased from 8.5 to 14.9; a 74% increase. OR utilization increased from 78% to 96%. Surgical admissions increased 72%. Occupied bed days per month increased from 398 to 724; an 82% increase. Outpatient specialty clinic visits increased 26%. Network referrals fell 28%. SCO related network charges dropped 29%. Prime containment metric improved from 64% in Aug to 75% by Nov. Coding accuracy jumped from 21% to 94%. And lastly, internal staff satisfaction improved 10%. If you have any questions or would like further information please call me at DSN 333-2465 or email me at: stephen.sales@usafa.af.mil.

Health Care Optimization (HCO) Update from Air Staff: Maj Wahl, AFMOA

- **What is HCO?**

HCO is a tool that the AFMS is using to deliver population health to our enrollees. Optimization means to make the most efficient and effective use of limited resources. Efforts have been underway to optimize Primary Care since 2000. Initiatives are now underway to expand optimization to Specialty Care. Specialty Care Optimization (SCO) includes the basic concepts and principles of PCO, but is tailored toward the specialty clinic product line. There are many concepts and processes that are common to both; customer service, team efficiency, access management, and demand forecasting. These concepts are the foundation of Health Care Optimization (HCO). Simplifying this, one could say that PCO + SCO = HCO.

- **Why do we need to "optimize"?**

We need the proper in-house capability in the correct sites/ markets to support Readiness at the most reasonable costs. Foremost focus is on Readiness currency because many of our specialists support wartime critical services. Closely tied to Readiness currency is Clinical Currency, and as we improve the Readiness Skills Verification of all the clinical staff, we have the potential to achieve better clinical outcomes for our patients. Efficiencies in practice are realized when we have the appropriate resources, sufficient staff, space, and equipment to treat patients. As we progress towards our Maximum Allowable Enrollment, our best potential for return on investment is health care optimization.

- **Which specialty clinics are being optimized?**

General Surgery, Orthopedics, ENT, Ophthalmology, and OB/ GYN are the five surgical product lines that have been analyzed to date. The Product Line Analysis and Transformation Team (PLATT) will complete the analysis on over 70 product lines by Oct 03.

- **What are the support staff ratios for SCO?**

For each physician, there will be authorizations for the following support staff:

OB/ GYN:	(1) RN, (2) 4N, (1) 4A, (.3) midwife, (.7) NP
Ophthalmology:	(3) 4N, (.7) 4A
General Surgery:	(.5) RN, (2) 4N, (1) 4A, (.25) PA
Orthopedics:	(1.5) 4N, (.5) 4A, (.6) PA
ENT:	(2.2) 4N, (1) 4A

5. How will my specialty care staff members get trained on HCO?

Training plans are under way to ensure that staff receive the training and information needed to improve the way they deliver care to their patients. MTFs that have 2 or more of the optimized product lines with 2 or more surgeons per product line will have on-site training between April 03 and April 04 (schedule included in attachment below). Additionally, a "Population Health Guide" which includes information on Health Care Optimization, is in draft and will be available to the field by April 03.

Cool quotes:

*"The harder you work, the luckier you get"...*Gary Player
*"Imagination is more important than knowledge"...*Albert Einstein
"The road to success is not doing one thing 100% better, but doing 100 things 1% better"…
H. Jackson Brown

Managing PCM-by-name Enrollments and Those Un-enrolled Patients, Lt Gill, Little Rock GPM

PCM By Name assignments are one of the key processes necessary to make PCO happen well. Assigning a patient a PCM is probably a smooth process at your MTF. Some places have contractors doing this function, while in others the MTF personnel are responsible for this function. Either way, CHCS makes assigning them a breeze.

However, have you ever looked at how many people are being seen in your primary care clinics that aren't assigned a PCM? Ask your appointment clerks; they'll tell you right away. This number can way get out of hand. Instead of focusing solely on the total number of unassigned patients you see, I'm here to shed some light on *why* they might appear that way in CHCS in the first place.

First, maybe the patient just didn't enroll at your facility (well "Duh, Lieutenant"). But, did you ever wonder why they never enrolled? Sometimes the Medical Right Start programs don't capture 100% of incoming personnel. Between the time they sign into the MPF, and receive an appointment date and time for your Right Start, they end up becoming "too busy" and skip out of your briefings (which is probably where you have enrollments started). And that's just the active duty. So, ensure you have processes that capture 100% of the newly assigned personnel, and try to get the active duty family members enrolled at that time also. A great example can be by looking at your base's Group and Squadron Commanders. We found over 60% of ours were not enrolled to us—all because of the way we catering to their needs and not having them go through a full Right Start. How many of yours are not enrolled?

Another reason they might not appear assigned to you in CHCS is caused by DEERS. Members will become temporarily ineligible in DEERS for various reasons (e.g. reenlistment/ separation dates pass without being updated, ID cards expire). If they remain ineligible for 48 hours, then CHCS will disenroll the member from their PCM and from your facility altogether. This is good—if the member is no longer actually eligible. However, if it is an administrative oversight that is corrected in DEERS soon thereafter, CHCS will not automatically reassign them to your facility or to their previous PCM. In this case, another NED transmission is required to reassign them. This can be a very significant problem as a new DEERS version now requires all dependents to have their SSANs entered in the next 90-days or else they will lose eligibility!

Initial enrollments can also be a problem in CHCS. If the DEERS information is correct, but the patient's information entered by the contractor is wrong (patient's SSAN, date of birth, etc.), then this can cause CHCS to reject the enrollment (which is usually called a "PIT Message Error"). Essentially, CHCS has enough doubt that the "NED" patient and the "CHCS" patient might not be the same. Changing some of the demographic information in CHCS or having the NED message retransmitted with the correct information can help to fix this.

Other reasons a patient has PCM assignment problems can come from changes in sponsors (divorce or remarriage). Maybe you have a large student population that you can't enroll at all. Or, you possibly have a transient population that you choose to see without being enrolled. Not all unenrolled patients seen are "problem patients." Just be aware of which are, and which aren't.

As you can see, there are a variety of reasons why a patient can seem to not be enrolled in CHCS. But, before you place all of the blame, and make the patient be solely responsible for fixing it themselves, see if there are ways you can rectify the situation on your end. You might just find that there is something wrong with your end. Having a good process in place to fix these issues will improve your enrollment numbers in CHCS. Plus, the patient will see the same provider more often. However, you'll have more satisfaction because the patients aren't having their enrollment status questioned each and every time they call to make an appointment.

GPMs and HCO: Share Your Scheduling/ Templating Skills, Lt Col Yoder, AFMOA

As GPMs become proficient at template management, they may want to branch out and help non-PCO clinics. This may be as a class offered at lunch or working one-on-one with a clinic NCOIC. What is in it for the GPM? Communication. When you work with the Orthopedic Clinic on their templates, you learn more about orthopedics and what they can do. Orthopedics can share with the GPM what is needed for a good referral (e.g., for pain, has the patient been treated conservatively) which will help the PCMs. Orthopedics will know you are a good troop and will be more open to help you. And of course, a great line for your OER - you not only made the primary care clinics work more smoothly, you helped all the clinics.

AFMOA GPM Update, Lt Col Haggerty

Since May is National Hospital month (among many other celebrations), I guess I'll use that venue to thank each of you for the important role you play as a GPM at each of your MTFs. Let me see if I can bring you up to date on a few developments within the AFMS that are/ will/ may be affecting you and your MTF.

Coding within the AFMS: This arena continues to be a "hotbed" of activity on many levels, both generically within the DoD, and specifically within the AFMS.

The Population Health Support Division (AFMOA/ SGZZ) has been providing feedback to DoD Health Affairs (DoD(HA))as they prepare to release a DODD and DODI concerning both coding and medical record retention within the DoD. I won't go into the details of the guidance yet (except to say that among the proposed requirements are periodic, random external coding audits; see what we are already performing below), since it is still in draft format, but suffice it to say that DoD(HA) is interested in assuring that coding within the DoD is complete, timely, and accurate and that medical records are complete, accurate, and available to the medical provider. ECD: 90 days post DODD/ DODI final approval and release.

Another area getting a lot of attention is the move into the Industry Based Workload Alignment (IBWA). Once fully implemented, IBWA will standardize the collection of ambulatory provider workload generated on the inpatient unit. Another way to look at the issue is that IBWA aligns the DoD practice with the private sector by transitioning the Standard Ambulatory Data Record (SADR) and Standard Inpatient Data Record (SIDR) to a "Professional" and "Institutional" record, respectively. Final guidelines are being developed by TMA with inputs from a Tri-service Tiger Team. ECD: May – Dec 03

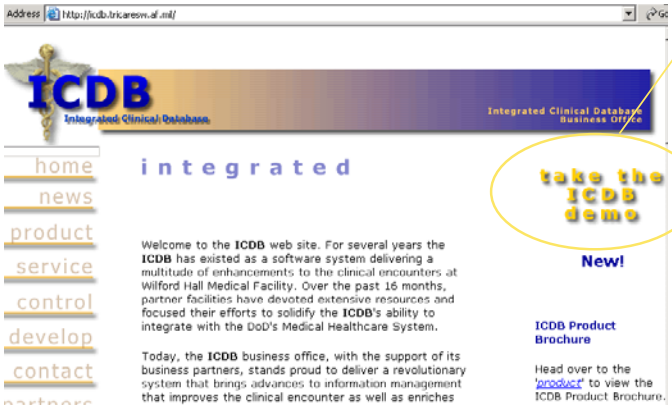
Expect to see your MTFs receive a new policy later this year which standardizes the process utilized by internal coding auditors at each MTF/ MAJCOM to conduct internal/ peer review coding audits. This will enable the collection of internal coding audit results and allow the comparison of these results within MAJCOMs and across the AFMS enterprise. Related to this is a goal to provide a coding accuracy metric for the AFMS on BDQAS and P2R2. ECD: Jun 03

There are two external coding audit initiatives underway at this moment; they differ in their approaches and methodologies. First, AFMOA/ SGZZ is working with 3M Health Information Systems (3M HIS) to conduct external coding audits of 43 Peer 3, 4, and 5 level MTFs across the AFMS. These MTFs were selected based on the size, volume, and complexity of the care provided to their populations. As of this newsletter, on-site audits have already been conducted at Keesler, MacDill, and Robins AFBs; several others MTFs are already scheduled. Prior to the on-site audit by 3M coding professionals, the MTF is provided a list of outpatient records to make available to their auditors; sample size is based on a 3M algorithm which looks at total volume of workload and diversity of care provided. Following the on site audit a final report is drafted for the MTF with suggested corrective action and a date approximately 30 days post-audit is arranged for 3M staff to conduct targeted coding/ documentation training for MTF clinical staff. All 3M HIS on-site audits should be completed during CY 03. At the same time, TMA has a contract with AdvanceMed to conduct external coding audits DoD-wide. In this audit, AdvanceMed, with TMA approval, selects 18 MTFs (6 from each service) each month and conducts an off-site audit of outpatient, inpatient, and ambulatory procedure visits (APVs). Each MTF selected is notified and then asked to pull a pre-selected list of patient encounters in these three areas, copy these encounters, and then send them via FedEx (provided) to the contractor for audit. These audits are anticipated to be completed by 1 Oct 03. Bottom Line: AFMOA/ SGZZ is attempting to de-conflict these audits, but has no direct involvement in the TMA audit. Also, as results of these audits become available we will share lessons learned with the field.

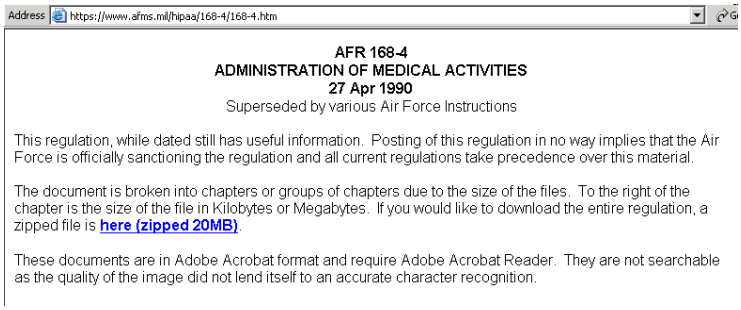
Before I go, I need to let each of you know that sometime later this year, as a result of the AFMS/ SG reorganization, the Population Health Support Division will transition from AFMOA/ SGZZ to the AF Medical Support Agency (AFMSA). Once completed our office symbol will be AFMSA/ SGOZ; we will, however, remain at Brooks City-Base, Texas. ECD Aug 03.

Take care and email me at joseph.haggerty@brooks.af.mil or call DSN 240-4774, if I can be of further assistance.

Cool Web Sites



1. ICDB Home Page and Demo...if you have not seen this yet, you need to:
http:// / icdb.tricaresw.af.mil/



2. AFR 168-4 Link (NOT AF policy...strictly for research purposes only...GREAT Patient Admin resource)

https:// / www.afms.mil/ hipaa/ 168-4/ 168-4.htm

3. New GPM Knowledge Exchange Website (still in Alpha testing mode)...will soon replace existing GPM Website. Has some really cool document sharing features...users guide on the way...check it out and watch for more details soon.

https:// / https:// / kx.afms.mil/ ctb/ groups/ dotmil/ documents/ afms/ knowledgejunction.hcst?

GPM Networking and Contact Information

Donald "Bulldog" Taylor, Col, USAF, MSC Email: donald.taylor@uke.af.mil DSN: 896-7500	Strategic/ Policy Issues
Joe Haggerty, Lt Col, USAF, MSC Email: joseph.haggerty@brooks.af.mil DSN: 240-4774	Operational Issues
Jerome "John" Hyzy, Maj, USAF, MSC Email: jerome.hyzy@sheppard.af.mil DSN: 736-1197	Training/ Tool Development Issues *For questions/ comments/ submissions for the GPM Newsletter, contact Maj Hyzy*